

Using the Chapelhow Framework to Deliver Nursing Care

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Abstract

Chapelhow et al. (2005) devised a framework consisting of six enablers which nurses must undertake to provide competent, objective and specialised nursing care. This case study focuses upon two enablers: assessment and communication, with reference to a patient's journey when admitted to a gastroenterology ward. Assessment and communication are important aspects of providing nursing care and this is demonstrated throughout this case study. Furthermore, they interlink to provide efficient nursing care; however, both are not without limitations. This is further explored throughout this case study.

Keywords

Chapelhow, Assessment, Communication, Nursing Care,

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The assumption that nursing care is merely the delivery of clinical skills, such as measuring blood pressure, is challenged by Chapelhow et al. (2005). They suggest six essential skills which enable the nurse to deliver expert, safe and effective healthcare: Page | 5
assessment, communication, professional judgement and decision making, risk management, record keeping and documentation, and managing uncertainty. This case study will discuss the care given to a sixty-eight-year-old male admitted to hospital whilst referring to two of the above enablers. The first enabler to be discussed will be assessment.

Assessment is fundamental to the safety, continuity and quality of care a patient receives (NMC 2018). Assessments allow holistic need-based care to be implemented (Miller and Webb 2011). The second enabler to be discussed will be communication. Chapelhow et al. (2005) propose communication is an essential nursing skill when undertaking assessment. According to O'Hagan et al. (2014) communication between patients and healthcare providers influences patients' outcomes and allows the development of a therapeutic relationship (NMC 2018).

The patient discussed in this case study will be referred to as 'Stephen'; a pseudonym to protect his identity and maintain confidentiality (NMC 2018). Stephen gave verbal consent for relevant information to be used within this case study (NMC 2018). He was informed how his information would be used and what information would be used (NMC 2018). He was admitted to hospital presenting with pallor, tachycardia and melaena; black stool due to digested blood caused by internal bleeding (Zhu et al. 2018). This resulted in a Hb

(Haemoglobin) level of 61 (g/L). Therefore, the oxygen saturation within Stephen's red blood cells was below normal as normal Hb levels for Stephen's demographics range between Hb118 and148 (g/L) (Sormunen 2010). This resulted in hypotension (Atsma et al. 2012). Hypotension is abnormally low blood pressure. Blood pressure is the force of blood pushing against the walls of the arteries as the heart pumps blood. The normal range for blood pressure in an adult is 120 systolic and diastolic of 80 mmHG (120/80mmHG), however hypotension is blood pressure that is lower than 90/60 mmHG (NHLBI 2018). This had reduced Stephen's mobility.

The first enabler to be discussed is assessment. Assessments allow for the evaluation of a patient's physical, mental, social and cultural needs (Howatson-Jones, Standing and Roberts 2015). Assessment is an interactive process during which the patient and nurse collaborate to identify patient need(s) through in-depth information provided (Chapelhow et al. 2005). Engagement with the patient is essential (Barrett, Wilson and Woodlands 2009). Failure to recognise and respond to the needs of patients can result in unmet care needs and is thus detrimental to one's wellbeing (McCormack and McCance 2010).

A comprehensive assessment followed Stephen's admission (Wade and Halligan 2017). Mayo (2017) and Bennett, Penny and Lawrence (2009) reiterate that completing comprehensive assessments allow comorbidities to be identified, deterioration of a patient's condition and provide appropriate care and treatment with the aim of optimising his/her well-being. Therefore, informed decisions were based upon current and best practice (Bennett, Penny and Lawrence 2009). This skill must be acquired during pre-

registration nursing (McCallum et al. 2013). Therefore, it is suggested assessments are an integral and essential skill for nurses, which in turn optimises a patient's well-being.

Stephen was assessed using quantitative and qualitative assessment methods. This enabled nurses to collate information to identify care needs (Taylor 2017). The National Early Warning Score (NEWS), Waterlow Pressure Ulcer Scoring System, Bristol Stool Chart and the Geriatric Depression Scale were used. Within the first six hours following admission, Stephen was assessed using the NEWS (RCP 2017). This provided a baseline for Stephen's respiratory rate, oxygen saturations, heart rate, blood pressure, temperature and level of consciousness (Prytherch et al. 2010). As Stephen had symptoms of internal bleeding, it was vital to repeat the NEWS every four hours to monitor this (RCP 2017). This provided staff with data to compare to baseline observations that were taken on admission (Tollefson, Bishop and Jelly 2011).

Stephen was assessed using the Waterlow Pressure Ulcer Scoring System (Waterlow 2008) within the first six hours following his admission (NICE 2015). This was implemented because upon completing the MUST (Malnutrition Universal Screening Tool), Stephen had a BMI (Body Mass Index) of 16 (kg/m²), considered underweight (Zaidi and Lanigan 2010) and had fragile skin and poor mobility. A BMI less than 18.5 (kg/m²) is considered underweight, a BMI ranging between 18.5 and 24.9 (kg/m²) is considered normal, a BMI ranging between 25 and 29.9 (kg/m²) is considered overweight and a BMI over 30 (kg/m²) is considered obese (Lukaski 2014). In addition, Stephen had both urinary and faecal incontinence. There was a need to ensure the care plan included

measures to reduce risk of pressure ulcers. Stephen was therefore repositioned frequently (Gillespie et al. 2014) and barrier cream applied to pressure areas to protect the skin (NICE 2014a).

When Stephen was admitted initially, his faecal output was not assessed. When this was recognised the Bristol Stool Chart was implemented to monitor melaena as it is considered valid and reliable for assessing an individual's stool (Chumpitazzi et al. 2016). Identifying the stool type, frequency of bowel opening, and the amount of faeces excreted against an objective chart enabled the correct treatment to be prescribed and administered (Bayless and Hanauer 2011).

As Stephen had hypotension, a fluid input/output chart was implemented. Hypotension can result in acute kidney injury whereby the nephrons do not produce urine regularly (Cockwell, Stringer and Marriott 2018) leading to reduction in excretion of waste and ultimately toxicity for the patient (Patton and Thibodeau 2016).

Stephen complained of feeling low in mood, especially since this deterioration of his physical health. The Geriatric Depression Scale (GDS), created by Yesavage et al. (1983) objectively assessed Stephen's depressive symptoms. The GDS is a screening tool used to identify depressive symptoms in adults over 65 years (Esiwe et al. 2016). Shorter versions of the GDS have been developed, albeit they lack the detail of the full version which could impact on the reliability and validity of the tool (Pocklington et al. 2016).

The GDS has 30 closed questions, making it easy to use (Lim 2008). However, due to the quantitative design, limited qualitative information will be present (Langridge and Hagger-Johnson 2009). As the GDS does not provide contextual information it should be used as a scaffold for treatment along with other tools (DiNapoli and Scogin 2017).

Stephen scored 19 on the GDS suggesting he was experiencing symptoms synonymous with mild depression (Li et al. 2015). However, it can be argued, as the cut off for an indicative score of mild depression is 10, environmental factors may lead to an increase in the score to major depression: a score of 20-30 (Li et al. 2015). However, Yesavage et al. (1983) found the three classifications of no depression, mild and major depression were valid, thus the three classifications were distinguishable. As Yesavage et al. (1983) developed the GDS, there could be interpreter bias which would reduce the validity of the above assertion (Langdrige and Hagger-Johnson 2009). Moreover, Xie et al. (2015) further validated these results and found the GDS was applicable to eastern cultures.

Negative attitudes often exist among nurses when caring for people with mental health issues (Lethoba, Netswera and Rankhumise 2006). Ross and Goldner (2009) completed a meta-review and found RGNs held the stereotypical assumption that patients on a general medical ward diagnosed or presenting as mentally ill were dangerous and unpredictable. Furthermore, RGNs often lack the confidence and skills to competently assess and manage a patient's physical and mental illness needs (Schreuders 2007). This empirical research is important because it suggests a dichotomy, stigma and failings of assessing a patient from a holistic viewpoint, thus neglecting patients' well-being.

Comprehensive assessments were implemented throughout Stephen's admission (Clarke 2014). This was integral to his care as it allowed the nurses to collate the necessary information to understand and prioritise his needs and implement treatment (Dougherty, Lister and West-Oram 2015). The patient is required to engage in the assessment process (Chapelhow et al. 2005); however, assessments do not consider if the patient is withdrawn, unable or unwilling to take part. Thus excellent communication skills on the part of the assessor are necessary to encourage the patient to engage (Tobiano et al. 2015).

The second enabler to be discussed is communication. Communication is the reciprocated exchange of information, verbally and non-verbally, between individuals (Dougherty, Lister and West-Oram 2015; NMC 2018). Within nursing, communication is interpersonal (NMC 2018, McCabe and Timmins 2013); the process by which a therapeutic relationship is developed where compassion, support and empathy is demonstrated (Bach and Grant 2015).

The NMC (2018) Code of Conduct posits nurses must communicate effectively with patients. O'Hagan et al. (2014) identify effective communication as dependent upon the nurse's approach, manner, interaction techniques, for example, using layman's terms and communication styles, for example, using the SOLER model.

Egan (1990) developed the SOLER model for listeners to ensure they are actively present when interacting, allowing the development of a therapeutic relationship with a patient.

SOLER is the acronym used where the listener Sits squarely, has an Open posture, Leans towards the patient, has good Eye contact and is Relaxed (Egan 2013). Crouch (2005) found the application of SOLER ensures patients feel uninhibited to express themselves as they have the listener's full attention, thus it is reliable and valid as a tool of effective communication.

As Stephen had depressive symptoms, the nurses used strategies to engage him with assessments (Bryant 2009). In addition, communication between the nurse and patient needs to include active listening. Active listening demonstrates to the patient the nurse is committed, supportive and caring (McCabe and Timmins 2013) which promotes empowerment and person-centred care (Gilmartin and Wright 2008). Active listening encouraged Stephen to give information, express his concerns and needs which allowed the nurse to holistically plan his care (Miller and Webb 2011). The absence of active listening can result in the patient feeling abandoned and disrespected (Barrere 2007; Gilmartin and Wright 2008).

One in four people experience mental illness (World Health Organization 2014) which can result in a communication difficulty. Depression can impair cognition (Wang and Blazer 2015) and reduce the ability to engage (Ayalon, Feliciano and Arean 2010). This could impact on patient care and well-being, so it is essential that nurses adapt to the patient's needs to enhance their well-being through adopting SOLER and active listening (Taylor 2017).

Effective communication is integral to delivering holistic, personalised and need-centred care (O'Hagan et al. 2014). It is a key determinant in patient recovery, satisfaction and perception of care and allows the establishment of interpersonal relationships between the nurse and patients admitted onto physical (McFadden et al. 2017) and mental illness wards (Kameg et al. 2009) and patients with severe communication impairments (Finke, Light and Kitko 2008). Therefore, nurses must be aware how their approach to patients influences the way a patient responds; thus, SOLER is integral to the promotion of patient well-being (Sale and Neale 2014).

During any involvement with the patient, the nurse should communicate to the patient to explain why and what they need to complete (Taylor 2017). This allows the patient to give their consent, essential before completing any care (Department of Health (DH) 2012), and treats the patient with dignity and respect (NMC 2018). Therefore, the patient is supported and involved in their care (Bach and Grant 2015). Rathert, Wyrwich and Boren (2013) found that involving patients in their care increased their satisfaction with the care and their well-being.

To reduce vulnerability to pressure ulcers on the sacrum and heels, Stephen's care plan outlined how he should be re-positioned to help assess and prevent ulcers and barrier cream applied: at least every six hours for those areas at risk and every 4 hours for those at high risk (NICE 2014b). Although Stephen consented to this care plan, before completing any care, Stephen's consent was sought (NMC 2018). Throughout this procedure nurses communicated with Stephen and provided a rationale. This allowed him

to ask any questions or discuss any issues he may have had.

Whilst empirical evidence demonstrates effective communication skills are integral to delivering patient-centred care, poor communication is still commonplace in some nursing environments (Mullan and Kothe 2010). Poor communication is a common complaint within nursing resulting in failure of effective care (DH 2013). The Mid Staffordshire NHS Public Enquiry (Francis 2013) found poor communication between healthcare staff and patients resulted in neglect, delayed treatment and preventable deaths. Cummins et al. (2018) have also reinforced the importance of communication. It can be posited that poor communication can impact upon the quality of care received. It is essential that communication is effective to enhance patients' care and ultimately their well-being.

Furthermore, communication includes how patients express their needs (Chapelhow et al. 2005). For example, a patient may be embarrassed, or scared to disclose information. Stephen was required to use a bed pan so that his faeces could be examined. Stephen initially stated the bleeding had stopped; however, nurses noticed Stephen was apprehensive and embarrassed. Empathy was required, and it was important he understood the reason why it was necessary for his faeces to be examined (Taylor 2017). Therefore, the nurse/patient relationship was essential in this instance and great sensitivity was required (Chapelhow et al. 2005).

The use of jargon is a major issue within healthcare (Silverman, Kurtz and Draper 2013). This can result in the patient feeling confused and frustrated, not comprehending what

nurses are verbalising (Connelly and Gupta 2017). Nurses need to communicate in clear and comprehensible language (Riley 2015).

However, it is essential patients are not patronised (Hanson 2014). However, Williams, Kemper and Hummert (2016) argue some nurses use 'elder-speak' to adults over 65 years old. Elder-speak is based on the stereotype that older adults are less competent, so healthcare professionals simplify their language, patronise and alter their tone of language (Williams 2011). Elder-speak was used towards Stephen. He found this insulting which had a detrimental effect on the therapeutic relationship between him and a nurse (Hanson 2014).

Poor communication occurred during Stephen's admission. Doctors explained to Stephen he had melaena; however, Stephen did not understand. Silverman, Kurtz and Draper (2013) argue patients rarely ask for clarification. This heightened his anxiety as he believed he had another physical illness. Recognising this, the nurses explained what melaena was and this appeared to reduce Stephen's anxiety.

Communication within the multidisciplinary team (MDT) is imperative. The enthusiasm for MDT work within healthcare reflects a profound recognition that working together can deliver improvements for the patient that might not otherwise be achieved (Clarke and Forster 2015). The benefit of the MDT is that each member brings their own skills and knowledge relating to their speciality thereby providing holistic care for the patient (Friedland et al. 2011). This allows for the team to develop mutual goals to enhance

patient well-being (Thomson et al. 2015). Therefore, the MDT provides personalised and holistic care and support (Speck 2006).

Stephen was reviewed by an MDT. He was assessed by the consultant and nurses within gastroenterology. A referral was made to the dietician as he was underweight. He was referred to psychiatric liaison, so they could assess and provide treatment for his depression (Page 2012). However, MDT working can be challenging. Atwal and Caldwell (2006) found different perceptions of teamwork sometimes hindered MDT working.

Stephen was *expressing* symptoms of depression; however, he did not have a formal diagnosis of depression. During handover, nurses stated Stephen had a *diagnosis* of depression, leading to misinterpretation by staff. Referral to Psychiatric Liaison was delayed until confirmation of the diagnosis. It is important to note a symptom is a change from usual state of functioning (Mulley and Albert 2010), whereas a diagnosis is the confirmation of an illness by examining the symptoms (Dougherty, Lister, and West-Oram 2015).

As Stephen was under the MDT framework, it was essential to maintain confidentiality (NMC 2018). Professionals were given relevant information. Whilst communication is essential for MDT working and completing assessments, confidentiality could be easily broken. Therefore, it is everybody's responsibility to ensure confidentiality is maintained (NMC 2018).

This case study has discussed the care given to Stephen, referring to two Chapelhow et al. (2005) enabling skills: assessment and communication. It has identified that effective communication was imperative for comprehensive assessments to be reliable and valid, suggesting these skills are not mutually exclusive. Using the case study of Stephen has demonstrated the importance of effective assessment and communication skills. These must be developed to optimise the care delivered. This case study has demonstrated how using different assessments can help assess a patient and their needs to ensure the most appropriate treatment is employed.

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